WELCOME TO OUR OFFICE

Mark A. Thompson, DDS,MS

PATIENT INFORMATION

PATIENT'S FULL NAME: NICKNAME:

DATE OF BIRTH: AGE: SCHOOL:

PHYSICAL ADDRESS

CITY, STATE, ZIP

HOME #: WORK #: CELL#:

IF PATIENT IS A MINOR, GIVE PARENT OR GUARDIAN'S NAME:

HOW DID YOU HEAR ABOUT OUR OFFICE?

RESPONSIBLE PARTY INFORMATION

FULL NAME: NICKNAME:

PHYSICAL ADDRESS:

CITY, STATE, ZIP: HOW LONG AT CURRENT ADDRESS:

MAILING ADDRESS: CITY, STATE, ZIP:

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS):

RELATIONSHIP TO PATIENT: DATE OF BIRTH: SOCIAL SECURITY #:

EMPLOYER: OCCUPATION: # YEAR EMPLOYED:

HOME #: WORK #: CELL:

MARITAL STATUS: ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ SEPARATED

SPOUSE'S FULL NAME: NICKNAME:

RELATIONSHIP TO PATIENT: DATE OF BIRTH: SOCIAL SECURITY #:

ADDRESS (IF DIFFERENT):

CITY, STATE, ZIP:

EMPLOYER: OCCUPATION: # YEAR EMPLOYED:

HOME #: WORK #: CELL #:

INSURANCE INFORMATION

SUBSCRIBER'S NAME: DATE OF BIRTH:

SOCIAL SECURITY#: GROUP #: INSURED'S EMPLOYER:

INSURANCE COMPANY NAME: PHONE #:

ADDRESS: CITY, STATE, ZIP:

DO YOU HAVE DUAL COVERAGE: ☐ YES ☐ NO IF YES, PLEASE CONTINUE.

SUBSCRIBER'S NAME: DATE OF BIRTH:

SOCIAL SECURITY#: GROUP #: INSURED'S EMPLOYER:

INSURANCE COMPANY NAME: PHONE #:

ADDRESS: CITY, STATE, ZIP:

FOR DOCTORS OFFICE USE ONLY.	EFFECTIVE DATE:_____ DEDUCTIBLE $:_____ PERCENTAGE:_____ CONTACT NAME:_____ LIMIT/MAX: $_____ ADULT AGE LIMIT:_____ DEPENDENT AGE LIMIT:_____ AMOUNT USED:_____ PAYMENT METHOD: AUTO/MANUAL = MONTHLY / QUARTERLY / BI-ANNUALLY / ANNUALLY / AT END OF TREATMENT

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU:

ADDRESS: HOME #:

CITY, STATE ,ZIP: RELATIONSHIP TO PATIENT:

✦ ✦ ✦ ✦ ✦ ✦

THIS OFFICE RESERVES THE RIGHT TO VERIFY THE CREDIT STATUS OF POTENTIAL PATIENTS AND/OR PARENTS OF PATIENTS BEFORE EXTENDING CREDIT FOR TREATMENT FEES AND MAY, AT THE DISCRETION OF THE OFFICE, USE THE SERVICES OF A CREDIT REPORTING SERVICE.

SIGNATURE (PARENT'S SIGNATURE, IF MINOR): DATE:

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WHO IS YOUR CHILD'S CURRENT DENTIST

DATE OF LAST CLEANING AND/OR CHECKUP?

HAS YOUR CHILD EVER BEEN EVALUATED FOR ORTHODONTIC TREATMENT?

DOCTOR'S NAME DATE OF TREATMENT

HAVE THERE BEEN ANY INJURIES TO THE FACE, TEETH, MOUTH OR CHIN?

IF SO, EXPLAIN

HAS YOUR CHILD EXHIBITED ANY OF THE FOLLOWING HABITS/CONDITIONS?

	Past habit	Current habit		Past habit	Current habit
THUMB SUCKING	❑	❑	LIP BITING	❑	❑
FINGER SUCKING	❑	❑	NAIL BITING	❑	❑
MOUTH BREATHING	❑	❑	GRINDING OF TEETH	❑	❑
TONGUE THRUSTING	❑	❑	SNORING	❑	❑

HAS YOUR CHILD EXPERIENCED JAW POPPING OR HAS THEIR JAW EVER LOCKED?

DOES YOUR CHILD HAVE FREQUENT HEADACHES?

IS YOUR CHILD STILL GROWING TALLER?

HAS MENSTRUATION BEGUN? (GIRLS)

IS YOUR CHILD UNDER THE CARE OF A PHYSICIAN?

IF YES, PHYSICIAN'S NAME

PLEASE LIST ALL THE DRUGS/SUPPLEMENTS YOUR CHILD IS TAKING AND FOR WHAT PURPOSE.

	DRUG / SUPPLEMENT	PURPOSE
1.		
2.		
3.		
4.		

PLEASE LIST THE DRUGS TO WHICH YOUR CHILD IS ALLERGIC:

DOES YOUR CHILD HAVE A HEART CONDITION/MURMUR REQUIRING ANTIBIOTIC COVERAGE FOR DENTAL WORK?

HAS YOUR CHILD HAD THEIR TONSILS OR ADENOIDS REMOVED?

HAS YOUR CHILD HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

RHEUMATIC FEVER	YES	NO	DIABETES	YES	NO
ASTHMA	YES	NO	HEPATITIS/JAUNDICE	YES	NO
SINUS INFECTION	YES	NO	HIV / AIDS	YES	NO
HEART TROUBLE	YES	NO	GLANDULAR DISORDERS	YES	NO
ALLERGIES TO: _____	YES	NO	OTHER MEDICAL CONDITIONS NOT LISTED	YES	NO

IF YES, EXPLAIN

I UNDERSTAND THE INFORMATION GIVEN IS CORRECT AND WILL BE HELD IN THE STRICTEST CONFIDENCE, AND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS.

PARENT'S SIGNATURE **DATE:**